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Ophthalmic Risk Management Digest

OMIC DIGEST

Evaluating Competency, Handling Incompetency

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All physicians, at some point, will find themselves in situations where they need to evaluate their own or another health care provider's competency. Especially when evaluating others' competency, physicians are often unsure of the best way to do so, how to communicate their evaluation to the subject, and their responsibility to report their findings. Viewing the issue from the patient safety perspective provides guidance. The following two OMIC case studies furnish a basis for considering the process.

A senior ophthalmologist was gravely concerned. This wasn't the first time his partner had run into problems with poor outcomes and dissatisfied patients. Four patients had even sued for medical malpractice about seven years ago. In each case, the other partners, OMIC, and defense experts had supported the ophthalmologist's care, and all four cases had been dismissed without an indemnity payment. Then one year ago, a patient experienced a ruptured posterior capsule. Uncharacteristically, the ophthalmologist didn't manage the complication well in the OR or during the postoperative period. Indeed, his attempts to recover the nucleus caused further damage. He never did a postoperative retinal exam despite worsening vision problems and never referred the patient to a retinal specialist. Discussing his care with the defense attorney assigned to assist him, the ophthalmologist was the first to offer the above criticisms, and agreed to settle the lawsuit against him for $160,000.

Now, nearly a year after that surgery, the group learned of four new cataract cases with poor outcomes, and all felt the surgeon's technique was clearly substandard. They had also noted changes in his behavior. The senior partner raised these quality and health concerns with his colleague at regular, short intervals—to no avail. The partners concluded that something was seriously wrong with their close friend and colleague and issued a mandatory order that he cease patient care. Their worst fears were confirmed when he was examined by a neurologist and deemed mentally incompetent secondary to frontal lobe dementia. Lawsuits based on the ophthalmologist's substandard care ensued, ultimately settling for a total of $850,000.

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MESSAGE FROM THE CHAIRMAN

One of the many benefits of the close relationship between OMIC and the Academy is the ability to coordinate our efforts to address legal, regulatory, and quality of care issues of common concern. Recently, OMIC and the Academy joined forces to stop legislation that would have adversely affected ophthalmic practice in two states.

In March, OMIC responded to a request from Academy EVP/CEO, David Parke, MD, to help the Washington Academy of Eye Physicians and Surgeons (WAEPS) respond to a proposed state Medical Quality Assurance Commission (MQAC) regulation that would characterize retrobulbar and periorbital ocular blocks as anesthesia "where significant cardiovascular or respiratory complications may result." Such a characterization would require every ophthalmology office that administers anesthetic blocks to undergo an accreditation or certification process similar to that of the Accreditation Association for Ambulatory Healthcare. Clearly, the process would not only be burdensome, but also extraordinarily expensive and unnecessary as ophthalmologists have been administering these anesthetic blocks in their office practices for decades with no significant risk to patients.

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Another ophthalmologist did not have the benefit of partners. When this young physician went out of town without arranging for coverage, and his patient presented to the ER with endophthalmitis, the on-call ophthalmologist did not contact him to raise concerns, opting instead to report him directly to the state medical board. Although the board supported the young physician's care, it noted that he had a higher-than-average rate of infection, and ordered him to write an article on endophthalmitis and submit his plan for coverage if he was ever again unavailable to see his patients after-hours. His well-researched article was accepted; but the board wanted more detail on his coverage plan. Rather than comply, he resigned his license, having already relocated to another state.

Pursuant to policies advised by the Federation of State Medical Boards, the first board contacted the second board to alert it to the physician's prior problems and licensure change. In the course of its own independent investigation, the second state's medical board was contacted by several patients and physicians, all of whom raised new quality of care concerns about this ophthalmologist. The board suspended his license, ordered a psychiatric evaluation, and later mandated six months of retraining and mentorship.

The academic eye center that agreed to retrain him was located in a neighboring state; it not only eventually assured the board that it was satisfied with his care, but offered him a position. The ophthalmologist has practiced there for several years without incident; nonetheless, ten patients in the second state ended up suing him. Defense experts raised the same concerns as the physicians who had contacted the state medical board. Eight of the ten lawsuits settled; indemnity payments ranged from $50,000 to $340,000, and totaled $1,795,000.

Everyday Competency Scenarios

Not all ophthalmologists will have to confront situations as complex as these two, but they will routinely face scenarios where they need to evaluate their own and others' competency. Consider these situations.

You are a comprehensive ophthalmologist and have many patients with AMD who require intravitreal injections. You would like to provide the care yourself instead of referring these patients to a retinal specialist. How do you evaluate your own competency?

You fracture your wrist. How do you know when you are able to perform surgery safely again? Do you need to disclose anything to your patients?

A physician you don't know calls you from the ER to discuss a patient. He feels the patient can be seen by you the next day. How do you assess the ER physician's competency to evaluate an eye condition? What should you do if you have concerns?

The senior partner in your practice is taking longer and longer to complete his surgeries and his complication rate is rising. How should you handle this?

A patient self-refers complaining of a surgical complication resulting from another ophthalmologist's care. Based upon the patient's history and your examination, you have no concerns about the prior care or surgery, even though the patient feels some mistake was made. How should you respond? How should you handle the patient if you do have concerns about the quality of prior care?

Your practice has decided to incorporate optometrists. How do you determine which patients they can see independently, which require a consult with an ophthalmologist, and which should be referred to an ophthalmologist?

Avoiding Harm, Meeting Ethical Duties

Every physician takes the Hippocratic oath, affirming a commitment to "first, do no harm." Doctors are also aware of ethical standards that impose a certain level of responsibility for ensuring that other physicians avoid maleficence as well. According to the American Medical Association, "A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities."

The American Academy of Ophthalmology encourages members who have a reasonable belief that another ophthalmologist deviated from the standards of patient care or ethics to take action to stop the questionable behavior. As a first step, the AAO recommends communicating directly with the eye surgeon. The Academy member should report the ophthalmologist to authorities only if such communication is ineffective or infeasible.

In both of the situations described earlier, physicians had concerns about the care rendered by another ophthalmologist. Those within the group practice communicated directly with their colleague about his results and his health. The ophthalmologists in the second case made no such attempt. It's unclear why they decided to report the physician to their state medical board as the first step. Perhaps they did not know the physician well enough or felt uncomfortable raising their concerns with him. They may have been direct competitors or had previous unpleasant encounters with this or another physician in similar circumstances. What is clear is that confronting and reporting incompetent physicians is a daunting task.

OMIC policyholders who have attended our risk management course on competency and incompetency at this year's state and subspecialty meetings have been asked to describe the barriers that prevent physicians from taking corrective action when they encounter another physician who is incompetent or impaired. Here are their responses.

Barriers to Taking Corrective Action

- Unprofessional to "break silence"
- Uncertainty about suspicions
- Not sure how to evaluate competency
- No access to physician's medical records
- Lack of personal observation of the physician's surgery or care
- Fear of seeing one's own incompetency
- Fear of retaliation from physician and/or community
- Risk of unintended consequences
- Fear of not being believed
- Fear of being wrong
- Fear of confrontation
- Compassion for incompetent/impaired colleague
- Unwillingness to impact physician's livelihood
- Don't know where to report concerns
- Peer pressure
- Loss of referrals
- Don't want to get involved
- Incompetent physician is in position of authority
- Reticence to judge others
- Rationalization of physician's behavior
- Extra work and time involved to resolve the problem
- No structured venue where issue can be raised without legal ramifications
- Conflict of interest
- Lack of faith that the medical board will handle investigation well

Moving the Conversation Into the Patient Safety Arena

Physicians had these same misgivings years ago when professional associations, insurance companies, hospitals, and regulatory agencies started encouraging them to discuss unanticipated outcomes with patients in a more forthright manner. The same principles evoked in ethical standards about competency run through articles on patient safety: first do no harm, honesty is the best policy, safety must be actively created. Just as patients have the need and the right to know their condition, treatment options, complications, outcomes, and errors, physicians have the right and the need to know of concerns, complaints, and errors attributable to them. Consider these conversations the second wave of disclosure discussions and opportunities to create safety by carefully evaluating all threats to it.

As part of ongoing efforts to monitor care and create safety, watch for signs of your own and your colleagues' incompetency or impairment. Early indications are often not clinical. Instead, they include complaints from patients, staff, and other physicians, a disruptive personality, difficulty creating and maintaining rapport with others, and a sense that the physician "does not play well with others." Studies have shown a clear link between poor communication skills and poor outcomes,[1] often starting in medical school. Don't ignore these signs or hope they will go away. Instead, remember that "inappropriate is unsafe" and investigate further.

Take Corrective Action

Research on patient safety has led us to recognize that medicine is a complex process, and that conscious effort is required to create safety. While a non-punitive approach to errors is advocated, it is also clear that disciplinary action, including mandatory remedial training, has its place. Some academic centers have developed models and programs to address competency concerns. For example, Vanderbilt University Center for Patient and Professional Advocacy describes an escalating approach. All physicians are monitored, and each complaint or concern is shared with the affected doctor, who is told that he or she "has a right and a need to know." Please see the **Hotline** article for suggestions on talking to physicians about competency concerns.

If concerns persist, a trained peer counselor meets with the individual in question and explains that other physicians are not generating the same number or type of complaints: "You are an outlier. Please review these materials before our next meeting." If the physician is unable or unwilling to take corrective action, a referral is made to an authority figure who considers whether a disciplinary response is warranted. If, as in the case of the second ophthalmologist, more training is needed, the physician will need to be referred to an academic center. One such center, the University of California, San Diego's Physician Assessment and Clinical Education (PACE) program, offers individualized evaluation and training for physicians whose medical boards or institutions have identified gaps in their knowledge, training, or communication skills.

Physicians are understandably wary of evaluating competency and managing incompetency and impairment. Institutions and professional associations, feeling the public pressure generated by regular stories of medical errors, are less reticent. Many are now requiring outcome tracking and ongoing quality review. OMIC policyholders who face these obligations are encouraged to seek assistance from our confidential Risk Management Hotline at (800) 562-6642, ext. 641.

1. Hickson GB, Federspiel CF, Pichert JW, Miller CS, Gauld-Jaeger J, Bost P. "Patient Complaints and Malpractice Risk." *JAMA* 2002 Jun 12;287(22):2951-7.